| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150010 | A. BUILDING _____ B. WING _____ | 07/22/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOSEPH HOSPITAL & HEALTH CENTER INC | 1907 W SYCAMORE ST KOKOMO, IN 46904 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>Surveyor: 27548<br>Facility Number: 005010<br><br>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey<br><br>Date of JCAHO On Site Survey - Hospital full survey July 18 - 22, 2011<br><br>Date of ISDH off site review - November 9, 2011<br><br>Reviewer/Surveyor - Billie Jo Fritch RN, PHNS<br><br>Based on review of the July 18 - 22, 2011 JCAHO Accreditation Survey Report, it has been determined that St. Joseph Hospital and Health Center meets the requirements for Hospital Licensure in Indiana. | S 000 | | |